SECTION V
COMMUNITY SUPPORT PROGRAM (CSP)
APPENDICES

APPENDIX 1
NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS FOR COMMUNITY SUPPORT PROGRAM (CSP) SERVICES
(For Claims Received on or after January 4, 1993)

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "not required" is specified.

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

ELEMENT 1 - **Program Block/Claim Sort Indicator**
Enter claim sort indicator "P" for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

ELEMENT 1a - INSURED'S I.D. NUMBER
Enter the recipient's ten-digit Medical Assistance identification number as found on the current Medical Assistance identification card.

ELEMENT 2 - PATIENT'S NAME
Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medical Assistance identification card. Specify if male or female with an "X."

ELEMENT 4 - INSURED'S NAME (not required)

ELEMENT 5 - PATIENT'S ADDRESS
Enter the complete address of the recipient's place of residence.

ELEMENT 6 - PATIENT RELATIONSHIP TO INSURED (not required)

ELEMENT 7 - INSURED'S ADDRESS (not required)

ELEMENT 8 - PATIENT STATUS (not required)

ELEMENT 9 - OTHER INSURED'S NAME
Third party insurance (commercial insurance coverage) must be billed prior to billing the WMAP, unless the service does not require third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook.

- When the provider has not billed other insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, the service does not require third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook, or the recipient's Medical Assistance identification card indicates "DEN" only, this element must be left blank.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook, one of the following codes MUST be indicated in the first box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part by other insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by private insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. DO NOT use this code unless the claim in question was actually billed to the private insurer.
OI-Y	YES, card indicates other coverage but it was not billed for reasons including, but not limited to: - Recipient denies coverage or will not cooperate; - The provider knows the service in question is noncovered by the carrier; - Insurance failed to respond to initial and follow-up claim; or - Benefits not assignable or cannot get an assignment.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by the WMAP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill the WMAP for services which are included in the capitation payment.

ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO (not required)

ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER
The first box of this element is used by the WMAP for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) If the recipient has Medicare coverage, enter the Medicare disclaimer code "M-8" since CSP is not a Medicare benefit.

ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE
(Not required since the provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 14 - DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (not required)

ELEMENT 15 - IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (not required)

ELEMENT 16 - DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (not required)

ELEMENT 17 - NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
When required, enter the referring or prescribing physician's name.

ELEMENT 17a - I.D. NUMBER OF REFERRING PHYSICIAN
When required, enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the WMAP provider number or license number of the referring provider.

ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (not required)

ELEMENT 19 - RESERVED FOR LOCAL USE (not required)

ELEMENT 20 - OUTSIDE LAB (not required)

ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
The International Classification of Disease, Ninth Edition, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. The first diagnosis listed is the primary diagnosis and must be one of the allowable diagnosis codes listed in Appendix 3 of this handbook. The diagnosis description is not required.

ELEMENT 22 - MEDICAID RESUBMISSION (not required)

ELEMENT 23 - PRIOR AUTHORIZATION (not required)

ELEMENT 24A - DATE(S) OF SERVICE
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service on the same detail line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing only the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD)

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services performed are identical.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge per detail line in element 24F.)

- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck indicator.
- All procedures have the same emergency indicator.

ELEMENT 24B - PLACE OF SERVICE
Enter the appropriate WMAP single-digit place of service code for each service. Refer to Appendix 5 of this handbook for allowable place of service codes.

ELEMENT 24C - TYPE OF SERVICE CODE
Enter "1" as the type of service code.

ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES
Enter the appropriate five-character procedure code. Refer to Appendix 4 of this handbook for a list of allowable procedure codes.

ELEMENT 24E - DIAGNOSIS CODE
When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

ELEMENT 24F - CHARGES
Enter the total charge for each line.

ELEMENT 24G - DAYS OR UNITS
Enter the total number of services billed for each line. A decimal must be indicated when a fraction of a whole unit is billed. All CSP services are one-hour procedure codes. When billing for fractions of an hour, units of service are indicated in either half-hour or one-tenth hour increments, using the rounding guidelines in Appendix 6 of this handbook.

ELEMENT 24H - EPSDT/FAMILY PLANNING
Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral.

ELEMENT 24I - EMG
Enter an "E" for each procedure performed as an emergency, regardless of the place of service.

ELEMENT 24J - COB (not required)

ELEMENT 24K - RESERVED FOR LOCAL USE
Enter the eight-digit, Medical Assistance provider number of the performing provider for each procedure, if it is different than the billing provider number indicated in element 33.

In counties where the 51.42 board contracts with a qualified CSP, enter the eight-digit non-billing/performing provider number of the contracted CSP. Refer to Appendix 2b of this handbook for a sample claim form of this type.

When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the WMAP Provider Handbook for information on recipient spenddown.

ELEMENT 25 - FEDERAL TAX ID NUMBER (not required)

ELEMENT 26 - PATIENT'S ACCOUNT NO.
Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

ELEMENT 27 - ACCEPT ASSIGNMENT
(Not required, provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 28 - TOTAL CHARGE
Enter the total charges for this claim.

ELEMENT 29 - AMOUNT PAID
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

ELEMENT 30 - BALANCE DUE
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER
The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

NOTE: This may be a computer-printed or typed name and date, or a signature stamp with the date.

ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (not required)

ELEMENT 33 - PHYSICIAN'S, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medical Assistance provider number.

APPENDIX 2a
THE 51.42 BOARD IS THE CSP

HEALTH INSURANCE CLAIM FORM

PICA

1 MEDICARE (Medicare #) | MEDICAID (Medicaid #) T | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2 PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3 PATIENT'S BIRTH DATE MM DD YY | SEX: M X F

4 INSURED'S NAME (Last Name, First Name, Middle Initial)

5 PATIENT'S ADDRESS (No., Street): 609 Willow

6 PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7 INSURED'S ADDRESS (No., Street)

CITY: Anytown | STATE: WI

8 PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-D

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-8

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M | F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 295.6
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 06 92		3	1	W8253		1	XX XX	1.0				
2 01 10 92		3	1	W8220		1	XX XX	0.5				
3 01 14 92	21 28	4	1	W8274		1	XX XX	4.5				
4												
5												
6												spenddown XX.XX

25. FEDERAL TAX I.D. NUMBER | SSN | EIN

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE: $ XXX XX

29. AMOUNT PAID: $

30. BALANCE DUE: $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M.Provider MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M.Billing
1 W. Williams
Anytown, WI 55555

PIN# GRP# 87654321

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (U2) (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 2b
THE 51.42 BOARD CONTRACTS WITH A QUALIFIED CSP

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #)	MEDICAID [P] (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)		
							0987654321		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY	SEX			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
Recipient, Im A.			MM DD YY	M [ ] F [X]					
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)		
609 Willow			Self [ ] Spouse [ ] Child [ ] Other [ ]						
CITY		STATE	8. PATIENT STATUS				CITY		STATE
Anytown		WI	Single [ ] Married [ ] Other [ ]						
ZIP CODE	TELEPHONE (Include Area Code)		Employed [ ] Full-Time Student [ ] Part-Time Student [ ]				ZIP CODE	TELEPHONE (INCLUDE AREA CODE)	
555555	(XXX)XXX-XXXX							( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER		
OI-D							M-8		
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (CURRENT OR PREVIOUS)				a. INSURED'S DATE OF BIRTH MM DD YY	SEX M [ ] F [ ]	
			[ ] YES [ ] NO						
b. OTHER INSURED'S DATE OF BIRTH MM DD YY	SEX M [ ] F [ ]		b. AUTO ACCIDENT?	PLACE (State)			b. EMPLOYER'S NAME OR SCHOOL NAME		
			[ ] YES [ ] NO						
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME		
			[ ] YES [ ] NO						
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
							[ ] YES [ ] NO If yes, return to and complete item 9 a-d.		

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
I.M. Referring	12345678	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
1. 295.6 2. 3. 4.		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 06 92		3	1	W8202		1	XX XX	1.0				11223344
2 01 08 92		3	1	W8253		1	XX XX	1.0				11223344
3 01 10 92		3	1	W8220		1	XX XX	0.5				11223344
4 01 14 92	21 28	4	1	W8274		1	XX XX	4.5				11223344
5												
6												spenddown XX.XX

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
[ ] [ ]	1234JED	[ ] YES [ ] NO	$ XXX XX	$	$ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I.M.Provider MM/DD/YY		I.M.Billing 100 W. Williams Anytown, WI 55555 87654321
SIGNED DATE		PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (U2) (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 3

WMAP ALLOWABLE CSP DIAGNOSIS CODES

Schizophrenic Disorders:	295.10 - 295.15 295.20 - 295.25 295.30 - 295.35 295.60 - 295.65 295.90 - 295.95
Schizoaffective Disorder:	295.70 - 295.75
Affective Psychoses:	296.20 - 296.26 296.30 - 296.36 296.40 - 296.46 296.50 - 296.56 296.60 - 296.66 296.7 311
Delusional Disorder N.O.S.:	297.1
Psychotic Disorder N.O.S.:	298.9
Autistic Disorders:	299.00 - 299.01
Neurotic Disorders:	300.01 300.11 300.14 300.16 300.19 300.21 300.3 300.4 300.81
Personality Disorders:	301.0 301.22 301.50 301.51 301.6 301.81 301.82 301.83 301.84 301.9
Anorexia Nervosa:	307.1
Tourette's Disorder:	307.23
Intermittent Explosive Disorder:	312.34

APPENDIX 4
WMAP ALLOWABLE PROCEDURE CODES FOR CSP

Procedure Code	Description
W8200	CSP Assessment & Treatment Planning - M.D.
W8201	CSP Assessment & Treatment Planning - Ph.D.
W8202	CSP Assessment & Treatment Planning - Master
W8203	CSP Assessment & Treatment Planning - Professional
W8210	CSP Transition to Community Living - M.D.
W8211	CSP Transition to Community Living - Ph.D.
W8212	CSP Transition to Community Living - Master
W8213	CSP Transition to Community Living - Professional
W8220	CSP Routine Psychiatric Services - M.D.
W8221	CSP Routine Psychiatric Services - Ph.D.
W8222	CSP Routine Psychiatric Services - Master
W8230	CSP Medication Prescription & Administration - M.D.
W8233	CSP Medication Prescription & Administration - Professional (R.N. only)
W8240	CSP Symptom Management & Supportive Psychotherapy - M.D.
W8241	CSP Symptom Management & Supportive Psychotherapy - Ph.D.
W8242	CSP Symptom Management & Supportive Psychotherapy - Master
W8243	CSP Symptom Management & Supportive Psychotherapy - Professional
W8250	CSP Case Management - M.D.
W8251	CSP Case Management - Ph.D.
W8252	CSP Case Management - Master
W8253	CSP Case Management - Professional
W8262	CSP Employment Related Skill Training - Master
W8263	CSP Employment Related Skill Training - Professional
W8271	CSP Psychosocial Rehabilitation - Ph.D.
W8272	CSP Psychosocial Rehabilitation - Master
W8273	CSP Psychosocial Rehabilitation - Professional
W8274	CSP Psychosocial Rehabilitation - Technician
W8280	CSP Group Therapy - M.D.
W8281	CSP Group Therapy - Ph.D.
W8282	CSP Group Therapy - Master
W8283	CSP Group Therapy - Professional
W8901	Clozapine Management

APPENDIX 5

WMAP ALLOWABLE CSP PLACE OF SERVICE CODES

For all procedure codes the following place of service codes are allowable:

POS	Description
0	Other*
2	Outpatient Hospital
3	Office
4	Home

For procedure codes W8210-W8213 (CSP Transition to Community Living), the following additional place of service codes are allowable:

POS	Description
1	Inpatient Hospital
7	Nursing Home
8	Skilled Nursing Facility

* It is not necessary to identify the actual place of service when place of service "0" is used. This code is used for locations not listed below.

APPENDIX 6

ROUNDING GUIDELINES

The following chart illustrates the rules of rounding and gives the appropriate billing unit(s).

Billing in Half-Hour Increments:

Time (in minutes)	Unit(s) Billed
1 - 30	.5
31 - 44	.5
45 - 60	1.0
61 - 74	1.0
75 - 90	1.5
91 - 104	1.5
105 - 120	2.0
121 - 134	2.0
etc.	

Billing in One-Tenth Hour Increments:

Time (in minutes)	Unit(s) Billed
1 - 6	.1
7 - 12	.2
13 - 18	.3
19 - 24	.4
25 - 30	.5
31 - 36	.6
37 - 42	.7
43 - 48	.8
49 - 54	.9
55 - 60	1.0
etc.	

APPENDIX 7

STAFF QUALIFICATIONS FOR CSP BILLING LEVELS

The Wisconsin Medical Assistance Program (WMAP) defines five billing levels for CSP staff. This appendix defines the level at which staff should bill based on their qualifications as listed in the CSP Administrative Code, HSS 63.06(2) and 63.06(4)(a).

M.D. . . . . . A psychiatrist who is a physician licensed under ch. 448, Stats., who has satisfactorily completed three years residency training in psychiatry in a program approved by the American Medical Association.

Ph.D. . . . . . A clinical psychologist licensed under ch. 455, Stats.

Masters . . . . . A person with a master's degree in social work, clinical psychology, or psychiatric mental health nursing, or equivalent requirements and having either 3,000 hours of supervised clinical experience in a practice where the majority of clients are adults with chronic mental illness or 1,500 hours of supervised clinical experience in a CSP.

CSP Professional . . . . . 1. A person with a bachelor's degree in a behavioral science or a related field with 1,000 hours of supervised post-degree experience with chronically mentally ill persons.

2. A person with a bachelor's degree in a field other than behavioral sciences with 2,000 hours of supervised post-degree experience with persons with chronic mental illness.

3. A registered nurse who holds a current certificate of registration under ch. 441, Stats., and who has experience or education related to the responsibilities of his or her position.

4. A person with a master's degree from a graduate school of social work accredited by the Council on Social Work Education, or a master's degree in a related field.

5. An occupational therapist or recreational therapist with a bachelor's degree in their respective profession.

6. A rehabilitation counselor who is certified or eligible to be certified by the commission on rehabilitation counselor certification.

7. A vocational counselor who shall possess or be eligible for a provisional school counselor certificate and who has a master's degree in counseling and guidance.

Mental Health Technician . . . . . A person who meets the requirements as defined in HSS 105.255 Wis. Adm. Code and reprinted on page 5H1-002 of this handbook.

APPENDIX 8
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF) FOR COMMUNITY SUPPORT PROGRAMS

ELEMENT 1 - PROCESSING TYPE
Enter the appropriate three-digit processing type from the list below. The "process type" is a three-digit code used to identify a category of service requested. Prior Authorization requests will be returned without adjudication if no processing type is indicated.

138 - Clozapine Management Services

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the recipient's 10-digit Medical Assistance identification number as found on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S NAME
Enter the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S ADDRESS
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

ELEMENT 5 - RECIPIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), as it appears on the recipient's Medical Assistance identification card.

ELEMENT 6 - RECIPIENT'S SEX
Enter an "X" to specify male or female.

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS AND ZIP CODE
Enter the name and complete address (street, city, state, and zip code) of the billing provider. ***No other information should be entered in this element since it also serves as a return mailing label.***

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the billing provider.

ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description most relevant to the service requested.

ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS
Enter the appropriate ICD-9-CM diagnosis code and description additionally descriptive of the recipient's clinical condition.

ELEMENT 12 - START DATE OF SPELL OF ILLNESS (not required)

ELEMENT 13 - FIRST DATE OF TREATMENT (not required)

ELEMENT 14 - PROCEDURE CODE(S)
Enter the appropriate HCPCS procedure code for each service requested, in this element.

ELEMENT 15 - MODIFIER (not required)

ELEMENT 16 - PLACE OF SERVICE
Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed. Refer to Appendix 5 of this handbook for a list of allowable place of service codes for CSPs.

ELEMENT 17 - TYPE OF SERVICE
Enter type of service code "1" for each service requested.

ELEMENT 18 - DESCRIPTION OF SERVICE
Enter a written description corresponding to the appropriate HCPCS procedure code for each service requested.

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED
Enter the quantity (i.e., number of services) requested for each service.

ELEMENT 20 - CHARGES
Enter your usual and customary charge for each service requested. If the quantity is greater than "1", multiply the quantity by the charge for each service requested. Enter that total amount in this element.

> *NOTE:*
> The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to Terms of Provider Reimbursement issued by the Department of Health and Social Services.

ELEMENT 21 - TOTAL CHARGE
Enter the anticipated total charge for this request.

ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT
An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Reimbursement will be in accordance with WMAP payment methodology and policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

ELEMENT 23 - DATE
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE
The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER - - THIS SPACE IS RESERVED FOR THE WISCONSIN MEDICAL ASSISTANCE PROGRAM CONSULTANT(S) AND ANALYST(S).

APPENDIX 9
PRIOR AUTHORIZATION REQUEST FORM (PA/RF) SAMPLE

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 138

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M ☐ F ☒

8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
Anytown CSP
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.: 87654321

10 DX: PRIMARY: 295.70 Schizo-affective disorder

11 DX: SECONDARY:

12 START DATE OF SOI: N/A

13 FIRST DATE RX: N/A

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W8901		4	1	Clozapine Management	26	X,XXX.XX
					TOTAL CHARGE	21 X,XXX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE)

24 C.S.P. Psychiatrist, M.D. (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

APPENDIX 10
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION CLOZAPINE ATTACHMENT (PA/CZA)

The information contained on this prior authorization clozapine attachment will be used to make a decision about appropriateness and length of time which will be approved for Medical Assistance reimbursement. Please complete each section as completely as possible and include any material which you believe will be of help in understanding the necessity for the services you are requesting. Where noted in these instructions, you may substitute material which you may have in your records for the information requested on the form. The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted. Complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

EDS
Prior Authorization Unit
6406 Bridge Road, Suite 88
Madison, WI 53784-0088

Questions regarding the completion of the Prior Authorization Request Form (PA/RF) and/or the Prior Authorization Clozapine Attachment (PA/CZA) may be addressed to EDS' Telephone/Written Correspondence Unit.

RECIPIENT INFORMATION:

ELEMENT 1 - RECIPIENT'S LAST NAME
Enter the recipient's last name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME
Enter the recipient's first name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Enter the recipient's middle initial exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the recipient's 10-digit Medical Assistance identification number exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 5 - RECIPIENT'S AGE
Enter the age of the recipient in years (e.g., 45, 60, 21, etc.).

PROVIDER INFORMATION:

ELEMENT 6 - PRESCRIBING PHYSICIAN NAME
Enter the name of the physician who is prescribing the Clozapine. The prescribing physician is that physician who is treating the patient.

ELEMENT 7 - PRESCRIBING PHYSICIAN NUMBER
Enter the nine-character DEA number of the prescribing physician.

ELEMENT 8 - PRESCRIBING PHYSICIAN TELEPHONE NUMBER
Enter the telephone number, including area code, of the prescribing physician.

DOCUMENTATION:

Copies of written and signed documentation may be substituted only if they provide the same information as that requested on the PA/CZA and are dated within two months of receipt at EDS.

Section I

1. Must be completed by a physician. Indicate diagnoses by code and description on all five axes from the current DSM.

2. On the initial request, this information should be historical and include justification for Clozapine treatment. Provider may attach copies of evaluations, treatment history, etc., if they support all the information requested, but these copies should not substitute for brief summary requested.

   On subsequent requests, it should be information updated since the previous request.

Section II
Previous Neuroleptic Medication should include all neuroleptic medication used during the past 10 years, or longer if the failed treatment occurred more than 10 years ago. Since Clozapine is recommended only after the failure of at least two neuroleptic medications, this section must be completed on the initial request. It must document the failures of two neuroleptic medications. This area does not need to be completed on subsequent requests. (Attach additional pages if necessary.)

Section III
Include hospital days for psychiatric disorders within the past six months, three years, and five years on the initial request. Include updated information on subsequent requests.

Record the number of hospitalizations that preceded those listed above.

Section IV Brief Psychiatric Rating Scale (BPRS)
Please complete the 24-point Brief Psychiatric Rating Scale (BPRS). The BPRS must be done in person by a clinician trained to assess mental status and must be dated within two months of receipt at EDS.

Section V
Document the prescribing physician's qualifications for prescribing neuroleptic medication. This area does not need to be completed on subsequent requests if the prescriber does not change. Papers showing credentials may be substituted.

Prescription
Attach a copy of the physician's prescription to the form. The prescription must be signed and dated within two months of receipt at EDS and should be of standard format (e.g., dosage and duration.)

Signature
The form must be dated and signed by the prescribing (treating) physician.

Section VI Additional Information
The information requested below is not used in adjudicating the prior authorization but is required for a long-term study of Clozapine. All information must be supplied on each request.

A. Social Status

   Please complete questions 1 through 6.

B. Medication Administration - Please answer questions 1 through 3. While these functions are the responsibility of the prescribing physician, this information offers some assurance that the management recommended by the manufacturer is being followed.

C. Current Medications - The list should include all drugs the patient is using currently or has used during the past month. A medication order record may be substituted.

D. Non-Medical Treatment - On the initial request, describe non-medical services the individual has received. Update information as necessary on subsequent requests.

APPENDIX 11
PRIOR AUTHORIZATION CLOZAPINE ATTACHMENT (PA/CZA) SAMPLE

Mail To:
E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/CZA
PRIOR AUTHORIZATION
CLOZAPINE ATTACHMENT

1. Complete this form
2. Attach to PA/RF
   (Prior Authorization Request Form)
3. Mail to E.D.S.

RECIPIENT INFORMATION

(1)	(2)	(3)	(4)	(5)
Recipient	Im	A	1234567890	26
LAST NAME	FIRST NAME	MIDDLE INITIAL	MEDICAL ASSISTANCE ID NUMBER	AGE

PROVIDER INFORMATION

(6)	(7)	(8)
I. M. Prescribing	xxxxxxxxx	(xxx) xxx - xxxx
PRESCRIBING PHYSICIAN'S NAME	PRESCRIBING PHYSICIAN'S DEA NUMBER	PRESCRIBING PHYSICIAN'S TELEPHONE NUMBER

SECTION I Diagnostic Information

1. Please give a current diagnostic statement for this patient including all 5 axes from current DSM manual.

Axis I: 295.70 Schizo - Affective disorder

Axis II: None

Axis III: None

Axis IV: Five-serious chronic illness

Axis V: 35

2. Description of patient's illness

Include onset and intensity of psychosis, current and past treatment history other than hospitalizations, symptom management and psychotherapy. Describe rationale for use, or continuing use, of clozapine.

Since 18 years of age, she has suffered from auditory hallucinations, paranoid delusions and manic episodes. Attends a community support program and has also participated in day treatment program. Clozapine is indicated because other neuroleptic medications have not alleviated symptoms.

SECTION II Previous Neuroleptic Medications

Previous Neuroleptic Medication (within past 10 years or longer if failures of medication occurred before that time)
(Not necessary on subsequent requests)

Drug name	Highest Daily Dosage	Date Start/End	Side Effects and/or Reason Discontinued
Haldol and Haldol Decanoate	30 mg PO 100 mg q 2wks	8/88 to Present	Remains on but continues to have delusions and hallucinations
Prolixin and Prolixin Decanoate	20 mg PO 50 mg q 2wks	7/87 to 7/88	No relief from hallucinations and delusions
Thorazine	500 mg	2/85 to 7/87	No relief from hallucinations and delusions

SECTION III Hospitalizations

1. Hospital days for psychiatric disorder within the past six months 13.
2. Hospital days for psychiatric disorder within the past three years 62.
3. Hospital days for psychiatric disorder within the past five years 150.
4. Number of hospitalizations for psychiatric disorder prior to last five years 10.

SECTION IV Brief Psychiatric Rating Scale (BPRS)

DATE ADMINISTERED: MM/DD/YY

The following 24-item version must be completed in person and must reflect the patient's current condition. Enter the number on the line using the scale value below that best describes the patient's present condition.

(1)	(2)	(3)	(4)	(5)	(6)	(7)
No problem	Very mild	Mild	Moderate	Moderately Severe	Severe	Extremely Severe

1. 4 Somatic Concern - preoccupation with physical health, fear of physical illness, hypochondriasis
2. 7 Anxiety - worry, fear, overconcern for present or future
3. 5 Depressive mood - sorrow, sadness, despondency, pessimism
4. 4 Guilt feelings - self-blame, shame, remorse for past behavior
5. 6 Hostility - animosity, contempt, belligerence, disdain for others
6. 7 Suspiciousness - mistrust, belief others harbor malicious or discriminatory intent
7. 5 Unusual thought content - unusual, odd, strange, bizarre thought content
8. 2 Grandiosity - exaggerated self-opinion, arrogance, conviction of unusual power or abilities
9. 7 Hallucinatory behavior - perceptions without normal external stimulus correspondence
10. 7 Emotional withdrawal - lack of spontaneous interaction, isolation, deficiency in relating to others
11. 3 Suicidality - expressed desire, intent, or actual actions to harm or kill self
12. 6 Self - Neglect - hygiene, appearance, or eating below social standards
13. 1 Disorientation - confusion regarding person, place or time
14. 6 Conceptual Disorganization - thought process confused, disconnected, disorganized, disrupted
15. 6 Excitement - heightened emotional tone, increased reactivity, impulsivity
16. 2 Motor Retardation - slowed, weakened movements or speech, reduced body tone
17. 2 Blunted Affect - reduced emotional tone, reduction in normal intensity of feelings, flatness
18. 7 Tension - physical and motor manifestations or nervousness, hyperactivity
19. 4 Mannerisms and Posturing - peculiar, bizarre unnatural motor behavior
20. 6 Uncooperativeness - resistance, guardedness, rejection of authority
21. 1 Bizarre Behavior - reports of odd, unusual or psychotically criminal behavior
22. 4 Elated Mood - euphoria, optimism that is out of proportion to circumstances
23. 7 Motor Hyperactivity - frequent movements and/or rapid speech
24. 6 Distractability - speech and actions interrupted by minor external stimuli or hallucinations and delusions

TOTAL: 115

SECTION V Prescribing (treating) Physician's Credentials

1. Are you a Board Certified or Board Eligible psychiatrist? Yes [X] No [ ]

2. If prescriber is not a psychiatrist, please provide documentation describing credentials as experienced in using neuroleptic drugs in clinical practice.

Attach a copy of the physician's prescription for clozapine. The prescription must be signed and dated and must cover the period of time being requested.

AUTHORIZATION IS GIVEN BASED ON INFORMATION SUBMITTED. RESPONSIBILITY FOR ASSESSING THE ADVISABILITY OF PRESCRIBING CLOZAPINE AND FOR ASSURING COMPLIANCE WITH ANY REQUIRED MONITORING LIES WITH THE PRESCRIBING PHYSICIAN.

04/15/92
DATE

I. m. Prescribing, m.D.
TREATING/PRESCRIBING PHYSICIAN

Recipient Name Im A. Recipient
Recipient MA ID # 1234567890

SECTION VI Additional Information

The information requested below is not used in adjudicating the prior authorization, but is required for a long-term study of clozapine.

A. Social Status

1. Legal guardianship and/or informal responsibility (check all that apply)

- [ ] Legal guardian established
- [ ] Spouse responsible
- [ ] Other legal oversight
- [ ] Other relative responsible
- [X] Resident/self responsible

2. Marital status (check one)

- [X] Single
- [ ] Separated
- [ ] Married
- [ ] Divorced
- [ ] Widowed

3. Current financial support other than SSI? Yes [ ] No [X]

4. Is patient currently employed? Yes [ ] No [X]

Paid job Yes [ ] No [ ] Type of work _____

# of hours per week _____ How long in position? _____

5. Is patient currently in school? Yes [ ] No [X]

If Yes, please check type of schooling:

- [ ] High School/GED
- [ ] Vocational
- [ ] College/University

6. Living situation. Please check one.

- [X] Private home/apartment/condo
- [ ] Retirement home
- [ ] Private room/rooming house
- [ ] Nursing home
- [ ] Homeless
- [ ] Other _____
- [ ] DOM/board and care home/group home/group residence

B. Medication Administration

1. Who is responsible for drawing blood for WBC? CSP coordinates it.
2. Who is responsible for reporting WBC results to physician/pharmacist? Lab
3. Who is responsible for overseeing clozapine administration? CSP staff.

C. Current Medications

Please list all known drugs presently taken by this patient. Include all drugs prescribed or used during the past month and the use of PRNs and over the counter medications.

Drug Name	Dosage Instructions/ Frequency	Date Started	Side Effects
Lithium CO_3	600 mg BID	3/88	Dry mouth
Lorazepam	2 mg PRN	4/89	None
Haldol	30 mg HS	8/88	None
Haldol Dec	100 mg lm q 2 weeks	8/88	None

D. Non-medical Treatment (continue on back)

Psychosocial and rehabilitation services, adequacy of community support, family involvement, CSP programming, etc.

Daily contact with CSP staff. Brother is very attentive, supportive. Lives with male friend who is supportive, calls CSP staff when she isn't doing well.